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Debriefing in the Emergency Department

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Clinical Leadership

Advocacy is the clinical nurse leadership theme for the project of implementing debriefing in the Emergency Department (ED). The global aim is to develop a Critical Incident Stress Debriefing (CISD) tool that will provide ED staff with a standardized, immediate and informal avenue for emotional processing and clinical care feedback. Previous studies show debriefing in the ED after critical incidents can promote teamwork, communication and improve patient care outcomes.

The clinical nurse leadership role is advocate and the competency is discover, disseminate and apply evidence for practice and for changing practice. This project requires a transformational leadership role involving collaboration among physicians and nursing staff to develop a tool and educate staff on how to facilitate a debriefing in the ED. The Forces of Magnetism represented in this project are Quality of Nursing Leadership and Management Style. The Forces of Magnetism are the foundation upon which Magnet recognized organizations guide their growth in healthcare (ANCC, 2016). As a leader and advocate for the staff, I will provide information based on previous research, explain the need for this process and listen to the feedback staff provide so that we can work together to make this project successful. Strong leadership can empower staff and improve care but we want to work beyond this and change practice to provide the best care for not only our patients but our staff.

Statement of the Problem

Lack of emotional support leads to burnout among staff in high-stress areas (Garcia-Izquierdo & Rios-Risquez, 2012). Emergency Departments are stressful environments and staff cope with acute and chronic stressors daily (Healy & Tyrell, 2011). Burnout is a response to the

chronic occupational stress caused by emotional exhaustion, cynicism and lack of personal effectiveness (Ríos-Risquez & García-Izquierdo, 2016). Hooper et al., (2010) found that more than 80% of emergency nurses have moderate to high levels of burnout. Burnout can lead to increased absenteeism, decreased satisfaction and turnover (Garcia-Izquierdo & Rios-Risquez, 2012).

Repeated exposure to stress as seen with ED staff, can have other types of consequences such as post-traumatic stress disorder (PTSD), compassion fatigue and secondary traumatic stress. Compassion fatigue is defined as a loss of a nurse's ability to nurture patients (Hinderer et al., 2014). Dominguez-Gomez and Ruteledge (2009) found that one third of 67 emergency nurses studied met criteria for secondary traumatic stress. The cascade of stress as it relates to compassion fatigue and secondary traumatic stress in ED nurses can lead to burnout, which can have a negative effect on patient care. As an ED nurse becomes stressed there is a possibility for poor patient interactions and patient care errors to occur. Ultimately leading to decreased patient satisfaction which can have financial implications for hospitals receiving reimbursement from the Centers for Medicare and Medicaid Services (Hinderer et al., 2014).

Emergency nurses that suffer from burnout can leave the department seeking a position that causes less stress. As nurses leave the ED, the department must replace these nurses. It is timely and costly to recruit and train new staff. Further efforts to fully staff the department with temporary nurses can have negative effects on patient care. New and temporary nurses may not be familiar with hospital policies or their environment, leading to potential delays and errors. Stress experienced by ED staff unfortunately cannot be eliminated due to the nature of the patients seen in the ED. However, identifying solutions to improve the work environment can minimize negative effects of stress and in turn may increase staff retention.

Project Overview

Mullan et al., (2013) defined debriefing as "a facilitated discussion of participant actions and thought processes to encourage reflection and assimilation of learning into practice." Defusing is solely to vent emotions and is differentiated from debriefing by Kessler, Cheng & Mullan (2014). Critical Incident Stress Debriefing (CISD) is a crisis intervention strategy designed to "mitigate the impact of traumatic events, facilitate the recovery process and restore adaptive functioning" (Maloney, 2012). Critical incidents have been defined as traumatic events causing a strong emotional response that an individual's usual coping mechanisms are ineffective (Magyar & Theophilos, 2010). Critical incidents can include: an incident with high stress levels, multiple disciplines or high patient acuity. This project further specifies critical incidents to include only patients, adult and pediatric, that undergo CPR or have a prolonged resuscitation while in the ED. The goal of implementing CISD in the ED is twofold. Initially we would like to see an improvement in staff satisfaction by subjective reports of feeling more supported in a high-stress environment. Secondly, we hope an improvement in teamwork and communication will ultimately lead to improved patient care outcomes. The use of the CISD tool customized to this ED will provide staff the opportunity to analyze our clinical care and provide an avenue for emotional processing.

The specific aim of this project is to debrief 75% of defined critical incidents in the ED and improve the staff's feeling of a supportive work environment by at least 50%, via a post pilot survey provided by the debriefing team. The CISD tool will provide staff a standardized, informal and timely emotional outlet, as well as a review of clinical care immediately following a critical incident. The debriefing team will review the CISD forms monthly and report feedback to staff. If the debriefing process is successful and staff report the CISD tool as helpful the scope

of critical incidents can be expanded to include trauma patients and any patient or situation the staff feel a debriefing would be beneficial.

By implementing a CISD tool, we expect that there will be an improvement in patient outcomes, an increase in the effectiveness of teamwork, a decrease in nursing burnout and nursing turnover, and an increase in staff satisfaction. Debriefings have been proven to increase teamwork and improve team morale. The positive outcomes of improving teamwork described by the AHRQ (2015) include: reduced length of stay, higher quality of care, better patient outcomes, a greater ability to meet family member needs, improved patient experience scores, and lower nurse turnover. Debriefing can also help to identify process improvements to improve the quality of care provided.

Rationale

Informal statements made in various staff meetings indicated low staff morale and dissatisfaction with the current work environment. Furthermore, recent staff surveys have shown responses such as: feeling unsupported, no immediate way to give clinical care feedback, and staff are generally unsatisfied with their work environment.

The ED microsystem assessment reveals staff working in the ED often face stressful situations with little or no avenue for emotional support (Healy and Tyrell, 2011). Current outlets for support are not conducive to treating ED nurses' stress because they often take place too long after the event or don't take place at all. The ED does not routinely debrief after critical incidents but does offer formal debriefing upon request. The formal debriefing process may happen days after the critical incident and include staff that may not have been involved in the actual incident. Maloney (2012) emphasizes that debriefing should happen as soon after the incident as possible,

"as the length of time between exposure to the event and CISD increases, the less effective CISD becomes."

ED nurses often face unsafe conditions due to the nature of the patients and see a wide variety of critical incidents including burns, trauma, medical codes, and psychological emergencies. As such, ED nurses have "a higher prevalence of PTSD than in the general population" (Lavoie, Talbot, & Mathieu, 2011). Healy and Tyrrell (2011), found that 97% of surveyed ED nurses and doctors have experienced stress. Respondents rated the top 4 stressors as work environment, aggression and violence from patients, death or resuscitation of a child or young patient, and resuscitation of critically ill patients. A root cause analysis of burnout in our ED, using a fishbone diagram, highlights the possible causes for stress experienced by staff leading to burnout and staff turnover (see Appendix A).

In order to assess staff perception of support and experiences with debriefing, ED staff were given an eight question questionnaire (see Appendix B). The survey was distributed through email to the entire ED staff of approximately 300 employees, with 88 responses. The first two questions asked if there is adequate support daily or for critically stressful events. Respondents overwhelmingly indicated there was not, with 66% and 81% respectively responding no. Only 41% of respondents have been involved in a debriefing at this ED. Time was identified as the largest barrier to debriefing (94%). Pediatric death was identified as the most requested situation for debriefing (90%). For those that previously participated in a debriefing (41%), all responded with positive comments. The comments were 100% positive and not one response discussed any dislikes of debriefing. Of those who specified types of support they would like to see (n=41), 75% identified debriefing as a preferred method of support.

Emergency departments have a high rate of turnover and burnout due to the stress of the job. Burnout can also lead to a significant economic loss through increased absenteeism, higher turnover rates and a rise in health care costs (Borritz et al., 2006). EDs are becoming more crowded and according to data from the California Health & Human Services Agency (2016) and Office of Statewide Health Planning and Development (2016), there has been an increase in visits in this ED per year, from just over 55,000 in 2009 to just under 71,000 in 2015. As a result, increased staffing levels are needed and high turnover rates impact daily staffing requirements. Not only can high staff turnover be problematic, the loss of high quality, seasoned nurses further negatively impacts the department.

Duffield et al., (2014) reviewed turnover costs for different countries with Australia topping at over $48,000 and the US, Canada and New Zealand ranged from over $20,000-$26,000. Training a new nurse for a 12 week orientation, working 40 hours a week, would cost approximately $25,000, based on 2015 wages. The preceptor working 36 hours a week during a 12 week orientation would cost $23,000. Combined, the cost of caring for patients over 12 weeks would be approximately $48,000 (UCnet, 2016). The Nursing Turnover Cost Calculation Methodology lists direct costs as: advertising and training, vacancies/temporary replacements and hiring and indirect costs as orientation and training, decreased new nurse productivity and termination. The costs of recruiting include the salaries and expenses of personnel for job fairs, seminars and advertising, as well as the costs for the events and their supplies. Direct costs to the department include: temporary nurses such as travel nurses or per diem staff, overtime of career employees to fill in the staffing gaps, and closed beds which leads to less revenue. Indirect costs of training include the training and preceptor staff salaries and the cost of termination which includes unused sick and vacation time. Decreased new nurse productivity refers to the period of

time while they are learning where they may not be as quick at patient turnover as more experienced nurses in the same institution. All of these costs can be mitigated by preventing burnout and improving nurse retention. By using Duffield et al., (2014) analysis of turnover cost in the US, if we can prevent just 4 nurses from leaving the ED in a year we can save the department approximately $100,000 (see Appendix C for a side by side cost comparison).

The direct cost of implementing the proposed debriefing process in the ED is estimated to cost $20. This includes the cost of a clipboard, paper for the debriefing tool, and a watch for the clipboard. The debriefing process does not bring in any extra staff that wouldn't have already been involved in the care of the patient and it requires no special training outside of education that will be presented at an already scheduled department education event. The debriefing team is meeting on their own time without compensation from the ED. However, there may be an indirect cost due to delay in treatment and throughput while staff take 10 minutes to participate in the debriefing. While this cost is difficult to calculate we anticipate delays will be minimal. The debriefing team plans to evaluate any impact the delays may have on patient flow.

Methodology

We will test if implementing CISD in the ED will lead to staff feeling more supported and provide a platform for clinical care review to take place. Lewin's Change Model has three stages (see Appendix D). The *Unfreezing* phase occurs when there is a realization that the current practice is not providing the ED staff with the support it feels necessary. Prior to the team coming together to implement the debriefing process, there was chatter in the department of dissatisfaction with the current state of increased volume and difficulty retaining staff. Therefore, staff are open to new processes to provide support after critical incidents. *Change*, the second stage, "occurs when individuals are offered options by way of an attitude change or a role

model" (Harris, Roussel & Thomas, 2014, p. 488). By providing a CISD process and tool we will be providing a role model for change. Nursing and physician leadership have provided support and encouragement for a culture shift. The third stage of Lewin's Change Model, *Refreezing*, will occur when the tool has been accepted by staff and implemented seamlessly into everyday practice.

Once CISD has been implemented in the ED our interdisciplinary team will collect the CISD forms and data (see Appendix E). The debriefing tool has an area to provide feedback if the tool was helpful and allows for explanation if not. Our team can gather feedback directly from the tool and evaluate regularly. We will also provide a post pilot survey and hope to see an increase in the number of staff that have participated in a debriefing. A post survey to staff will allow them to give feedback about whether they feel more supported by the implementation of CISD in the ED. We hope to see greater than 50% improvement in staff reporting a supportive environment. Predictions can be made based on previous research. Evidence shows that the barriers to debriefing in the ED include: heavy workload, time constraints, limited space, lack of qualified leaders, discomfort in environment and fear of criticism or judgment (Zinns et al., 2015). We find these to be similar constraints faced in this pilot project as indicated by the SWOT analysis performed (see Appendix F). However, research also suggests that when debriefings are performed they are reported as helpful. Our goal is to see debriefing after 75% of CPRs and prolonged resuscitations. We can expect difficulty in performing the debriefing but positive reactions when debriefings are performed.

Data Source/Literature Review

This Emergency Department is a Level 1 Adult and Pediatric Trauma Center serving 33 counties from Fresno to the Oregon border and East to Nevada. This ED sees just over 70,000

patients annually with 68 beds, eleven of which are specifically for pediatric patients (UC Davis Health System, 2015). The ED is staffed with RNs (approx. 150), attending physicians, residents, and medical students from all specialties as well as respiratory therapists, radiology technicians, ED technicians, phlebotomists, registration clerks, and various ancillary staff. The ED treats all patients regardless of sex, age, gender, socioeconomic status, medical history or medical insurance status.

The focus of this literature review is to evaluate if debriefing is an effective tool to increase staff support in the ED. The PICO statement that guided this literature search was: For Emergency Department staff would a standardized, immediate and informal stress debriefing after critical incidents help to decrease stress and reduce burnout, compared to current to practice? A literature review is provided below.

Lavoie, Talbot & Mathieu (2011), identify that emergency nurses experience PTSD symptoms and explain what can be done to improve interventions. In this qualitative study, 12 ED nurses participated in a primary investigator conducted one-on-one interview. The purpose of the interview was to evaluate the participants recognition of stressful events, how the stressful event made them think and feel and how they knew the event was stressful (Lavoie, Talbot, & Mathieu, 2011). The researchers brought nine of the twelve participants into a focus group to identify activities that could be helpful for ED nurses. Three categories were identified where PTSD symptoms were reported: exposure as a witness, exposure as a victim and contextual exposure. Participants with more ER experience reported more cases of exposure as a witness and contextual exposure. The participants identified the interventions currently used to manage stress as; feeling listened to, initiating security measures, taking part in a debriefing or defusing activity, and getting support from a colleague or supervisor, as essential (Lavoie, Talbot, &

Mathieu, 2011). This study surveyed the needs of the participants in order to design a support program to decrease symptoms of PTSD in ED staff. This study shows the current gap of support for ED staff to improve staff wellbeing and in turn provide quality patient care.

Mullan, Wuestner, Kerr, Christopher, & Patel (2013), implemented an in situ qualitative debriefing tool for resuscitations, and used a standardized protocol for debriefs. Subjects included all team members whose patients were resuscitated in the pediatric ED from May 2011 to May 2012. A total of 63 (26%) debriefings were performed of the 241 resuscitations that occurred during the study time period. Significantly higher debriefing rates were seen with patients who had CPR performed (77%) and patient outcome resulting in death (88%). The average time to start a debriefing was 33 minutes, median duration time was 10 min and the debriefing leader was the physician team leader (PTL) 90% of the time. The comment section of the Debriefing In Situ Conversation after Emergent Resuscitation Now (DISCERN) tool identified themes of teamwork, co-operation/coordination, communication and situational awareness. The DISCERN tool also identified negative PTL outcomes as: the PTL was not the only person giving orders and confusion identifying the team leader (Mullan, et. al, 2013). Of the debriefings with one of the negative PTL outcomes identified 29% of the patients died in the ED, whereas only 19% of patients died in the debriefings where neither negative PTL outcomes were identified. The Mullan et al., (2013) study implemented the DISCERN tool in order to: measure the rate of debriefing that occurred, describe area for performance improvement, and identify the practicality of which this tool could be used in emergency settings. The Mullan et al., (2013) study indicates; emergency department staff if given the opportunity would like to debrief, debriefing does not take a long time and it can happen very soon after the incident. This study also identified performance improvement themes and a direct correlation to deaths in the ED.

Healy and Tyrrell (2011), chose a descriptive study design and devised a questionnaire that was disseminated to 150 ED nurses and doctors working in three Emergency Departments in Ireland. The authors of this study wanted to document the opinions and experiences of stress among ED staff and how the stress is managed. The response rate was 69% with 103 respondents, 90 being nurses and 13 being doctors. The average age of the respondents was 33.4 years and average years of experience working in the ED was 6.9 years. Respondents (97%) reported experiencing stress in the ED where they worked and 51% of the respondents had experienced stress frequently or very frequently. The most common identified stressors were work environment, aggression or violence from patients, death or resuscitation of a young patient, critically ill patients, and sudden or traumatic deaths (Healy & Tyrrell, 2011). The most frequently identified stressor was work environment, which included: inadequate staffing, excessive workload, overcrowding, staff conflict, lack of teamwork and unsatisfactory management. The second most frequently identified stressor was aggression or violence by patients. Increasingly ED staff are physically abused by patients and these findings correlate with similar study findings. Respondents (74%) reported they received no assistance from their employer to deal with the stress. Of the respondents who reported their employer provided support only half felt that the support was adequate. In Ireland, the Department of Social and Family affairs estimated that 67% of all occupational injury benefit claims in 2006 were the result of stress (Healy & Tyrrell, 2011). Interesting findings of Healy and Tyrrell (2011) included, more experienced ED nurses found death or resuscitation of a young patient more stressful than nurses with less ED experience and no significant differences were found between male and female and the number of workplace stressors experienced, however females found incidents involving family to be more stressful. The stress management strategies were not

discussed in detail but some participants identified informal discussion with colleagues as helpful.

Zinns et al., (2015) surveyed pediatric emergency medicine (PEM) fellows to determine the frequency and comfort level at which they debrief following medical resuscitation. A 10 item, anonymous questionnaire was distributed to 393 active pediatric emergency medicine (PEM) fellows in the United States with 201 responding. Almost all (99%) of the PEM fellows had participated in a medical resuscitation but 30.5% had never participated in a post-resuscitation debriefing (Zinns et al., 2015). The debriefings were noted to have begun within 6 hours of the resuscitation and 65.5% of the time lead by the PEM attending. Zinns et al., (2015) found that only 15.6% of the PEM fellows reported feeling comfortable leading a debriefing. The most important findings included 86.5% of the time the debriefings did not follow a structured format and 91.5% of respondents were interested in learning more about debriefing after medical resuscitation (Zinns et al., 2015). Due to the lack of structure, fellows may not have felt comfortable facilitating debriefings. Interestingly, there was no correlation between the number of medical resuscitations the PEM fellow participated in and the number of debriefings. Therefore, debriefing continues to be inconsistent in emergency practice. Barriers identified by the PEM fellows included heavy workload, time constraints, limited space, lack of qualified leaders, discomfort in environment and fear of criticism or judgment (Zinns et al., 2015). The Zinns et al., (2015) findings were consistent with previous research showing inconsistent use of debriefing in ED settings and encouraging signs of interest in learning about debriefing by respondents.

Maloney (2012), discusses the lack of information surrounding emotional support for healthcare professionals as well as burnout, the effects of stress and CISD as an intervention to

combat stress. Compassion fatigue and secondary traumatic stress is related to burnout and is defined as "a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment" (Maloney, 2012). Repeated exposure to stress, as in the daily care provided by ED staff, can have lasting effects similar to PTSD and other psychological symptoms such as: depression, anxiety, withdrawn behavior and substance abuse. Maloney (2012) discusses there is evidence that links stress to poor patient outcomes and medical errors. The goal of CISD is to assist in emotionally recovering after trauma exposure. Maloney (2012) suggests CISD should be located near the event and as soon as possible.

Magyar & Theophilos (2010), provide a literature review of research for and against debriefing in the ED. Again, it is shown that ED staff exposed to repeated traumatic events can develop signs of PTSD and therefore providing staff with a CISD tool can increase staff satisfaction, group morale and reduce short-term stress reactions. There was one study reviewed by Magyar & Theophilos that found debriefing to be harmful to participants, however, this study looked at participants who had primary trauma exposure such as burn patients or motor vehicle accident patients. Rose et al., did not study participants that have been exposed to secondary trauma and therefore may not apply to the population that is the focus such as ED staff. Magyar and Theophilos (2010), also described other models of debriefing such as early intervention, psychological first aid, and employee assistance programs. All models are not focused on providing support tailored to a unique population such as ED staff. The ED staff have circumstances such as time and space that create difficulty in implementing an emotional support tool that may be meant for a longer and more structured environment to provide counseling after critical incident exposure. The employee assistance programs as reviewed by Maygar & Theophilos (2010), may have limited value if they are not internally provided and offer support

unique to the organization. Again, Magyar & Theophilos (2010), point out that there is a lack of evidence for or against CISD but there is a perceived desire for CISD. They recommend further research focused on populations that are exposed to secondary trauma and ideally goals of assessing immediate, short-term stress responses.

Kessler, Cheng & Mullan (2014), provide a practical guide for debriefing in the ED. Debriefing has a process improvement component to identify areas of performance improvement and improve patient outcomes. A debriefing should include clinical management, technical skills, teamwork and behavioral issues (Kessler, Cheng & Mullan, 2014). An identified barrier is the debriefing facilitator and lack of training for this important role. Many studies have used the physician that leads the resuscitation as the facilitator but Kessler, Cheng & Mullan (2014) point out the scribe RN could also be a valuable facilitator. Debriefings should include open-ended questions and provide a safe, comfortable and judgement free environment. One certain method has not been identified as the most appropriate and Kessler, Cheng and Mullan, (2014), suggest a custom tailored CISD tool may be the most appropriate for each organization. Again, the timeframe of immediately following the critical incident is identified as best practice and the location is identified as a top barrier. Standardizing the debriefings by using a CISD tool, closing the loop after areas of improvement have been identified and having a centralized person that assesses the perceived benefit of CISD are also identified areas to make implementing CISD in the ED successful.

In summary, Lavoie, Talbot & Mathieu (2011) highlight that ED nurses identified debriefing as essential to managing stress. Mullan, Wuestner, Kerr, Christopher & Patel (2013) found that ED nurses and physicians using the DISCERN tool reported higher numbers of debriefing and showed improved patient outcomes. Healy and Tyrell (2011) identified ED nurses

as having increased levels of stress and a lack of support in dealing with the stress. Zinns et al., (2015) identified barriers and inconsistency of debriefing in the ED, which helps to plan for such barriers when implementing the pilot project in our ED. Maloney (2012) further identified the effects of stress, burnout, compassion fatigue and secondary traumatic stress on ED nurses and agreed that there is a lack of emotional support. Magyar & Theophilos (2010) performed a review of the literature that shows ED nurses have increased levels of stress and signs of PTSD and implementing any type of stress management in response to critical incidents can provide relief for staff. Kessler, Cheng & Mullan (2014), provide a guide to developing a tool and implementing debriefing as well as suggesting customizing the tool for the specific institution may provide better results.

Timeline

In August 2016, the ED staff were surveyed about their knowledge and experience with debriefing because it was identified there was a need for a more supportive work environment. The initial information gathering phase included an interdisciplinary team of ED nurses and physicians. Since September 2016 our team has met, analyzed survey results, discussed literature reviews and developed a tool for CISD in the ED. Our team is currently still working on finalizing the debriefing tool and educating the staff (see Appendix G). We hope to complete the education portion by December 2016. Beginning January 2016 we will launch the pilot project and it will last approximately one month. The tool itself provides feedback and data that we plan to collect weekly. In February 2017, our team will analyze the data and initial feedback. If the proposed tool appears sufficient for staff and no further changes in the process are needed, traumas will be added to the list of critical incidents. Using the CISD tool after traumas may take

a longer time to implement as traumas include staff that rotate through the department and are not included in our core ED staff. After 6 months (July 2016), we will re-survey the ED staff. In addition to the same eight questions provided in the pre-pilot survey, we will assess teamwork, communication and other areas of the work environment that could be improved. In August 2017, the team will start evaluating patient outcomes that may have been effected by the debriefing process.

Expected Results

The staff survey results identify the strong desire for more support in the ED and lead our team to believe that staff will be receptive to CISD. Initially staff may feel that there is not sufficient time to perform a quality debriefing, however our team has developed a process map that provides an efficient approach to debriefing (see Appendix H). Evidence shows that the barriers to debriefing include heavy workload, time constraints, limited space, lack of qualified leaders, discomfort in environment and fear of criticism or judgment (Zinns et al., 2015). We find these to be similar constraints faced in this pilot project. We expect to see an increase in number of staff that have participated in a debriefing and a greater than 50% improvement in staff rating this ED as a supportive environment. We realize staff may not feel comfortable facilitating a debriefing, as some comments in the staff survey mentioned formal CISD training. However, the CISD tool guides staff through standard statements and questions so that there does not have to be any improvisation. As staff participate in debriefings on a regular basis, we hope that communicating feedback or emotions becomes comfortable. CPR was identified as one of the top scenarios that staff would like to debrief after. Therefore, we expect to see debriefings occur after 75% of CPRs and prolonged resuscitations. Understandably there will be a learning

curve and it may be difficult to find the time and space. Yet, research also suggests that when debriefings are performed they are reported as helpful. We can expect difficulty in performing the debriefing but positive reactions when debriefings are performed.

Nursing Relevance

Debriefing in the ED is relevant to nursing in many ways. Our current understanding of staff working in high stress environments, is that they show higher levels of psychological effects related to stress. The significance of implementing debriefing in a high stress environment such as the ED, is to impact burnout. By providing an emotional support tool that can be implemented in a highly chaotic environment we hope to prevent nurse burnout. Nursing is a lifelong profession that can be cut short due to burnout. We would like to improve the work environment so that ED nurses can stay in this environment longer and provide high quality patient care. “In institutions were nurse burnout was high, patient satisfaction was low. In today’s healthcare environment, this is highly relevant to nursing practice and sustainability” (Hinderer et al., 2014). As a Magnet recognized organization we value nurse satisfaction. Nurses should be satisfied with their environment and the care they provide. Repeated exposure to stress causes nurses to become unsatisfied with their work environment. By providing an avenue for emotional processing and hopefully stress relief, nurses can feel supported and be satisfied with their work environment. If successful, debriefing can impact the cost of burnout. We can decrease absenteeism, turnover and health care costs by providing staff with an emotional outlet and an avenue for peer feedback.

Peer feedback provides participants with an educational opportunity to understand many aspects of the event. Nursing education often happens in real time and on the job. Debriefing

allows staff to ask why. “Adults need to talk through their experiences to get a deeper understanding of a situation” (Shore, 2014). Using open ended questions, during a debriefing, staff have the opportunity to verbalize their concerns and allow others to provide rationales. Allowing staff to ask questions after an incident and providing them an emotional outlet enables closure of the experience (Shore, 2014).

Summary Report

In order to improve staff support, reduce burnout and staff turnover the global aim of this project is to develop a Critical Incident Stress Debriefing (CISD) tool that will provide ED staff with an immediate and informal avenue for emotional processing and clinical care feedback. The specific aim is to debrief 75% of defined critical incidents and improve subjective reporting by staff of a more supportive work environment, by more than 50%. The Emergency Department staff work at a Level 1 Adult and Pediatric Trauma Center and have a high volume of approximately 71,000 patient visits a year. The ED staff include RNs, attending physicians, residents, medical students, emergency trauma technicians, and many ancillary staff.

The debriefing team includes both nurses and physicians from the ED. Initially, the ED staff completed a survey identifying their knowledge and experience with debriefing and what types of support they would like to see. Overwhelmingly, the results of the survey showed the strong desire for a more supportive environment especially after critically stressful events. Many respondents of the survey specifically identified debriefing for support. We took the results from the staff survey, reviewed previous studies and developed a CISD tool that addressed staff concerns and would work well in our department.

The implementation of CISD in the ED uses an adaptation of the previously studied DISCERN tool. The idea is that providing staff with a standardized tool will decrease the variation amongst different facilitators and increase debriefing frequency. Initially our team identified any medical emergency that met department criteria for a department "944 code" would require debriefing. The goal was to debrief at least 75% of these identified medical codes. However, the staff felt there are many medical codes that are called erroneously and requiring debriefs after all "944 codes" will decrease the importance of debriefing. There is concern that staff will view the debriefing process as just another task added to the already heavy workload. Therefore, our debriefing team decided to focus on adult and pediatric CPRs and prolonged resuscitations. We would like to see an increase in the number of staff that have participated in a debriefing, as well as an increase of greater than 50% of people that report this ED as a supportive work environment.

Stress experienced by ED staff unfortunately cannot be eliminated due to the nature of the patients seen in the ED. However, identifying solutions to improve work environment and increase staff retention can decrease the negative effects of stress on staff and patient care. Magyar & Theophilos (2010) showed implementing any type of stress management in response to critical incidents can provide relief for staff. Mullan et al., (2013) utilized the DISCERN tool to debrief and reported higher numbers of debriefing and showed improved patient outcomes. We hope that by implementing a process that not only allows the staff to take a minute to assess their own personal needs but also identify strengths and weaknesses related to the clinical care we provide, staff will feel supported and less stressed.

Results are unavailable because the implementation of CISD will not start until January 2017 (see Appendix G). We plan to analyze results and reevaluate the DISCERN tool as we go. The DISCERN tool can continue to be adapted as the needs of the staff change (Kessler, Cheng & Mullan, 2014). By not setting the tool in stone we can modify the program to stay current with the culture and the needs of the staff, so that, the tool will not become outdated or not useful. The tool is standardized in that each debriefing facilitator is guided through statements and questions. From experience, when staff identify a product or process as beneficial they will adopt it easier than something that seems unnecessary.

Sustainability will depend on support from both leadership and staff. The support from leadership on both the physician and nursing side is so important when implementing a process that may not directly benefit the goals of throughput and patient care, but are seen as important to the overall morale of the staff. The stakeholders of our department leadership are very supportive of implementing debriefing in the ED. The goal is to see an improvement in staff satisfaction especially in their work environment which has been seen to improve staff retention and ultimately lead to better patient care. The focus on patient satisfaction has been increasing in our institution and we often design processes to improve patient satisfaction. Unfortunately, we lose sight of the needs of our staff and focus more on the patient. Buy in from staff is ultimately the most important factor for long term sustainability of this process. As a member of the debriefing team, I play an integral role in advocating for staff and this project. In this project I hope to exemplify a transformational leader by evolving our practice to provide the best care for not only our patients but also ourselves.

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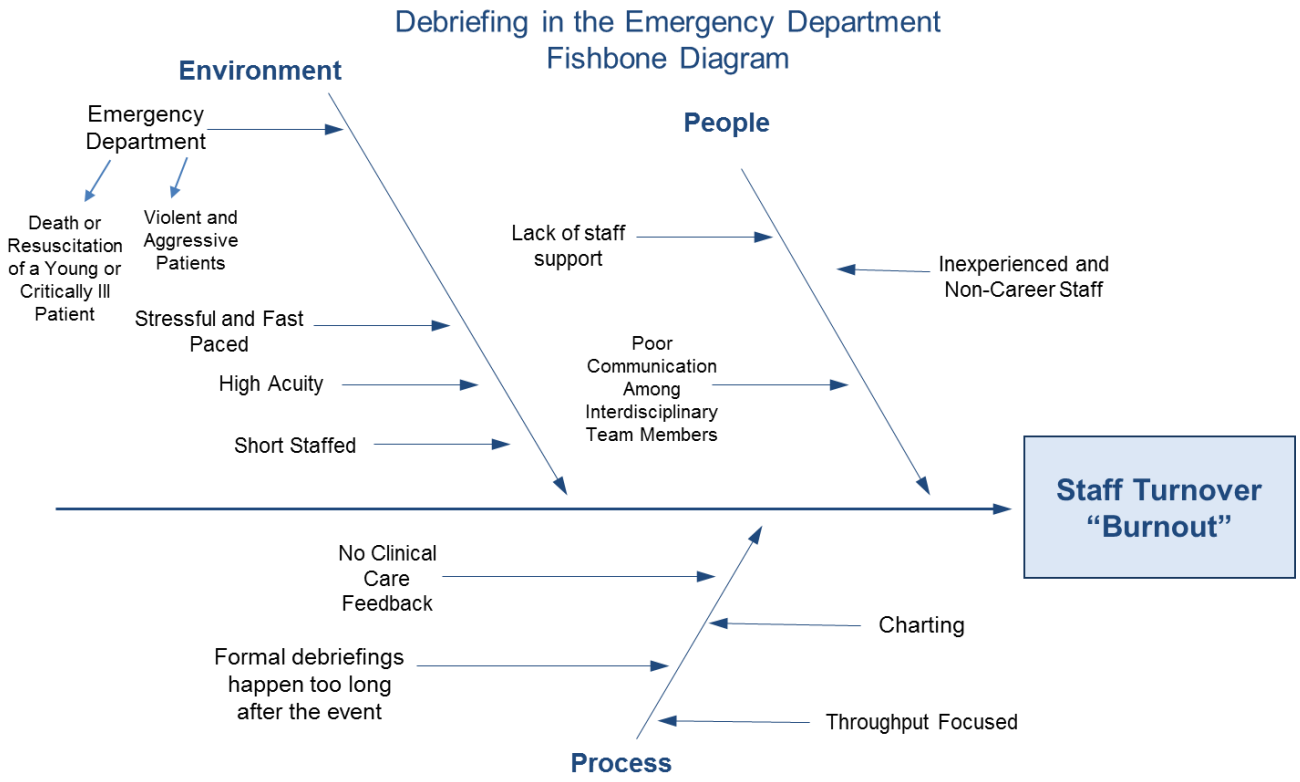
Appendix A

Fishbone Diagram



Appendix B

Staff Questionnaire

via Survey Monkey

1. Do you feel there is adequate support for staff for the daily challenges we encounter?

- **Yes**
- **No**

2. Do you feel there is adequate support for staff for the critically stressful events that occur?

- **Yes**
- **No**

3. Have you had experience with debriefings before?

- **No**
- **Yes, at UCD**
- **Yes, at another facility**
- **Yes, in EMS**

4. If yes, what did you like about them? What didn't you like?

- **Open area for response**

5. What are some barriers to performing a debriefing that you see?

- **Time**
- **Not needed**
- **Not well received by staff**

6. What kind of situations would you want a debriefing for?

- **Code**
- **Pediatric Death**
- **Resuscitation of person staff knows**
- **Palliative care patient**
- **Severely impacted ED shift**
- **A time when "everything went wrong"**
- **A time when "everything went right"**

7. What kind of support would you like to see?

- **Open area for responses**

8. Any other comments?

- **Open area for responses**

Appendix C

Side by Side Cost Comparison

COST COMPARISON

Debriefing	COST
Equipment	$20
Training	$0
Staff	$0
TOTAL COST	$20.00

New Staff Training	COST
Preceptor	$23,000
Preceptee	$25,000
Education	$250
TOTAL COST	$48,250.00

Appendix D

Lewin's Change Model

Appendix E

CISD Tool

Adapted from:

Debriefing in Situ Conversation in Emergency Room Now (DISCERN) Form

DO NOT SCAN OR PUT INTO PATIENT CHART - PLACE IN COMPLETED FORM FOLDER ON BACK OF CLIPBOARD

Debrefing in Situ Conversation in Emergency Room Now (DISCERN) Form

This info is privileged and confidential, protected by California Evidence Code 1156 and 1157

Advice for Team Debriefing

1. Pick a quiet or isolated place if possible - Anyone present during the event may lead a debriefing. Thank members for being present and encourage participation.
2. State: "The purpose of debriefing is for education, quality improvement & emotional processing. It is not a blaming session and is non-punative."
3. State: "If you have urgent issues to attend to you may leave at any time, however participation is welcome and encouraged. Feel free to ask questions."
4. State: "I will briefly review the patient care summary and then we as an entire team can discuss what went well and what could have been improved."
5. You as the facilitator will provide a brief summary of the event (<1 minute). Then proceed to discussion.

Patient Sticker or
MRN_____

Data

1. Date (MM/DD/YY): _____
2. Debrief Location: _____
3. Time Debriefing Started: _____
4. Check Criteria:
   - ☐ CPR ☐ Complex Resuscitation
   - ☐ Other:
5. Time Resus Ended: _____
6. Patient Outcome:
   - ☐ Alive ☐ Expired
7. Team Members Present:
   - ☐ Attending ☐ RT ☐ Pharm
   - ☐ Social Work ☐ ED Tech ☐ Charge RN
   - ☐ Residents # ____ ☐ RNs # ____ ☐ EMS

Time debriefing ended: _____

Further supportive resources listed here:

Discussion

Is everyone emotionally able to assess our clinical care at this time?

If NO: Would anyone like to speak about how they feel?

Does anyone need to step away for a moment?

ONLY proceed to next questions if group indicates readiness to assess clinical care

What went well? *(Intervention or Procedure, Teamwork, Communication, Leadership)*

What could have gone better? *(Intervention or Procedure, Teamwork, Communication, Leadership)*

Does anyone have questions? *(Interventions, Communication, Ethics)*

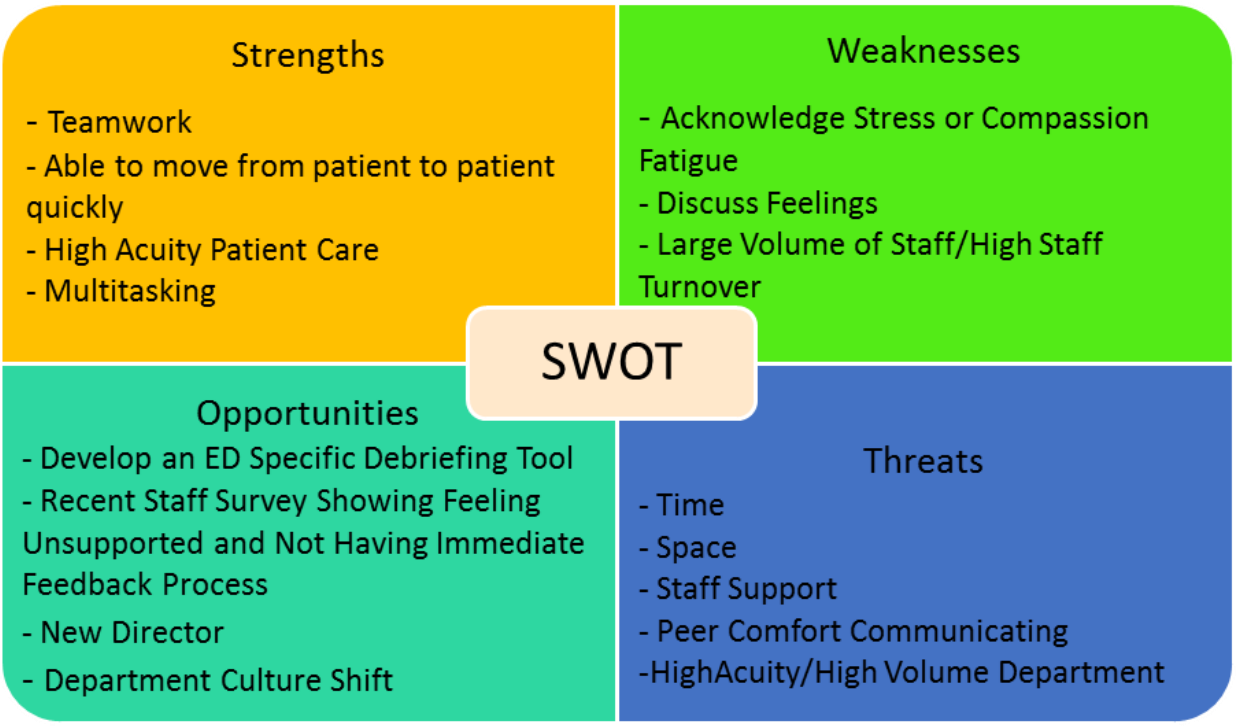
Was this form helpful? ☐ Yes ☐ No

If not, briefly explain why:

Reference: Kessler, D.O., Cheng, A., & Mullan, P.C. (2014) Debriefing in the emergency department after clinical events: A practical guide. Annals of Emergency Medicine 65(6), 690-698.

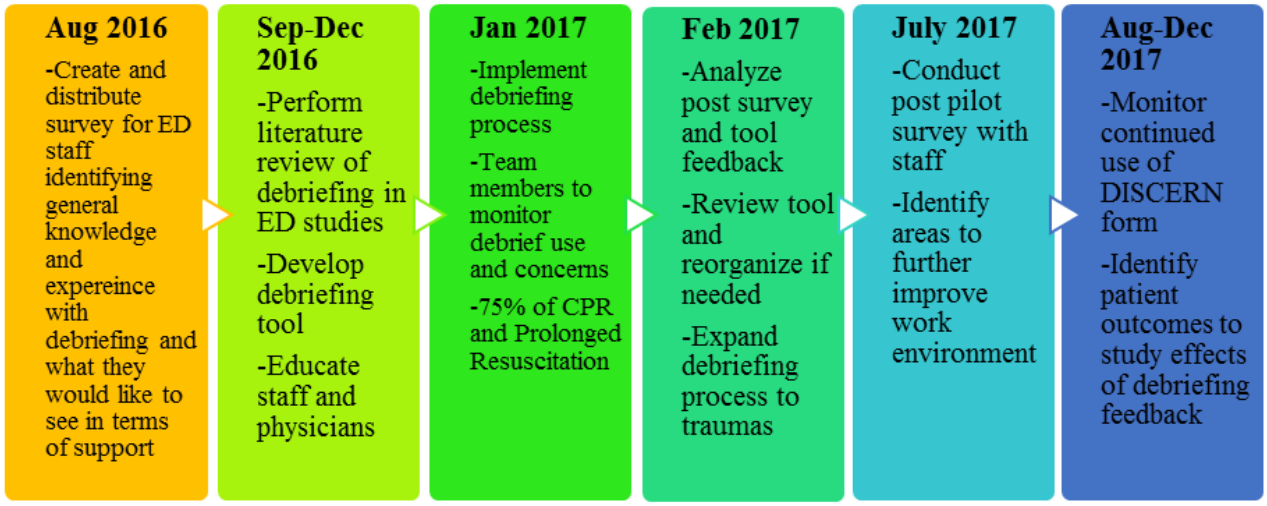
Appendix F

SWOT Analysis



Appendix G

Time Line



Appendix H

Process Map